DOCUMENT RESUME

ED 442 062 CG 030 206

AUTHOR Day, Susan X; Schneider, Paul
TITLE The Subjective Experiences of Therapists in Face-to-Face, Video, and Audio Sessions.
PUB DATE 2000-00-00
NOTE 17p.; In: Cybercounseling and Cyberlearning: Strategies and Resources for the Millennium; see CG 030 191.
AVAILABLE FROM American Counseling Association, 5999 Stevenson Ave., Alexandria, VA 22304-3300 ($29.95). Also available through ERIC Clearinghouse on Counseling and Student Services, University of North Carolina at Greensboro, 201 Ferguson Building, P.O. Box 26171, Greensboro, NC 27402-6171; Tel: 800-414-9769 (Toll Free); Fax: 336-334-4116; e-mail: ericcass@uncg.edu; Web site: http://ericcass.uncg.edu.
PUB TYPE Reports - Research (143)
EDRS PRICE EDRS Price MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS *Audiovisual Communications; *Counselors; Internet; Perception; *Psychotherapy; *Teleconferencing
IDENTIFIERS Online Counseling; *Video Teleconferencing

ABSTRACT

Most psychotherapists hold preconceptions about what it could be like to deliver services using distance technology. Reactions to distance technology in counseling have been governed by guesses rather then by experience or research. However, a recent teletherapy project has provided insight into how remote systems of treatment actually are perceived. This chapter first describes how the project, the Telehealth Project, was set up and implemented, and then examines six themes that emerged from analyses of the comments of participating therapists. Findings strongly suggest that technologically mediated treatment may be a substitute for, and in some cases an improvement upon, traditional face-to-face therapy. No insurmountable barriers were found. Adaptability of both clients and therapists was impressive. Implications for clinical training and practice are briefly explored. Further research is needed on the best ways to train clinicians and work around the problems distance therapy presents. With the proper support and consultation, the well-trained practitioner already holds the tools needed to send his/her touch through cyberspace. (MKA)

Reproductions supplied by EDRS are the best that can be made
from the original document.

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION
CENTER (ERIC)
☐ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

15

PERMISSION TO REPRODUCE AND
DISSEMINATE THIS MATERIAL IN
MICROFICHE ONLY HAS BEEN GRANTED BY

J. Jaco

TO THE EDUCATIONAL RESOURCES
INFORMATION CENTER (ERIC)

2B

ED 442 062

The Subjective Experiences of Therapists in Face-to-Face, Video, and Audio Sessions

SUSAN X DAY AND PAUL SCHNEIDER

Most psychotherapists hold preconceptions about what it could be like to deliver services using distance technology. Some might say, "The physical presence of the client is absolutely necessary for a working alliance," and others might say, "The nonverbal cues I get from my clients are essential to my case conceptualization." Both comments suggest that remote contact is felt to be a poor substitute for face-to-face communication. The question of whether psychological contact over a distance is the same as a relationship built by people in the same room is vital in these days of teleconferences, e-mail friendships, and chat room romance (e.g., Kraut et al., 1998). Reactions to distance technology in counseling have been governed by guesses rather than by experience or research. However, a recent teletherapy project has provided insight into how remote systems of treatment actually are perceived. It is the only large, empirical project on the subject known to this chapter's authors.

This chapter first describes how the project—the Telehealth Project—was set up and implemented, and then examines six themes that emerged from analyses of the comments of participating therapists. Implications for clinical training and practice are briefly explored.

CG030206

BEST COPY AVAILABLE

THE TELEHEALTH PROJECT

From 1997 to 1999, the authors of this chapter executed a research study to compare psychotherapy delivered face-to-face, over video teleconference (viewing each other on television monitors), and over audio-only conference (analogous to telephone) (Day, 1999; Schneider, 1999). We set up a clinic at which clients were assigned randomly to one of these technological conditions, and other variables were held constant: that is, the type of therapy delivered was mainly cognitive-behavioral; all clients attended five sessions; the same therapists did the counseling; a variety of client problems was accepted in each condition; and each condition involved the same physical setting—the Psychological Services Center at the University of Illinois at Urbana-Champaign. By June 1999, 26 or 27 clients in each condition had completed a five-session treatment at our clinic, well exceeding the median number of clients per group in psychotherapy research so far, which is 12.

In the case of the two-way video conference delivery mode, the setting consisted of two rooms, each with a video camera, one trained on the therapist and one on the client. Each of these cameras was then routed through VCRs in order to tape both the client and the clinician. From the VCRs the route continued to two 20-inch television monitors, one in each room displaying what went on in the other room. In the audio mode, each client used a hands-free audio system to connect and speak with the therapist. This therapy was delivered in the same rooms, using the same technology as the two-way video system. The only difference was that the video display was disabled for both the client and the clinician. Face-to-face dyads sat in one room together, with a video camera focused on each party. Therapists and clients in the video and audio modes never saw each other in the flesh at any time.

The study thus provided a unique group of clinicians who had delivered psychotherapy in all three conditions under closely comparable circumstances. Each of the therapists performed under all three conditions—face-to-face, video, and audio. The therapists were able to report on their perceptions of the three conditions and their subjective experiences of working with each. As each therapist left the project, he or she was interviewed on tape concerning sub-

jective points of view on working in the three conditions. They were asked about their preferences, their perceptions of effectiveness, changes they saw in their techniques according to condition, their ideas about individual differences in responses to the technology, whether certain problems seemed better and worse for teletherapy, and so forth. The tapes were transcribed, and both authors of this chapter separately read the transcripts according to traditions of qualitative research, looking for common themes running through the therapists' experiences. These themes are the findings reported in this chapter.

The 10 therapists participating in the assessment and treatment of our clients were members of an advanced practicum group supervised by doctoral-level psychologists. All therapists were doctoral students in clinical or counseling psychology at the University of Illinois; cognitive-behavioral treatment is part of both curricula and was the suggested type of therapy delivered in our clinic. This type of therapy is understood to be empirically validated, especially in time-limited treatments (DeRubeis & Crits-Christoph, 1998). These student clinicians had completed practica at the master's level already; all had completed further practica at the doctoral level or had also held jobs as therapists. Their hours of practicum and on-the-job experience ranged from 1,250 to 3,200, including experience in community mental health centers, university counseling centers, the Illinois Department of Rehabilitation Services, Veteran Affairs medical centers, Latina Liaison, forensic clinic, rape crisis center, vocational advisement, and sexual harassment clinic. Thus they brought solid backgrounds of experience as touchstones for comparing their experiences on our project. Therapists participated at varying levels, seeing between 3 and 30 clients and staying with us for 3 to 24 months.

SIX THEMES

In analyzing the transcripts, we identified six themes that came up repeatedly. Contextual information is provided on each theme, and then the therapists speak for themselves on these matters through direct quotations from the interviews. This helps to capture the flavor as well as the content of their remarks.

Theme 1: Emotional Connections: Mixed Reactions

Videotapes from all conditions were rated by a team of judges on a range of behaviors reflecting the working alliance between the therapist and the client. This alliance is often seen as the "active ingredient" in any treatment and as a necessity for success. The variables construed as representing the alliance were therapist exploration, client participation, and client hostility (inversely). A multivariate analysis of variance revealed no significant differences in any of these variables across face-to-face, video, and audio conditions. In other words, trained raters, who were practicing psychotherapists themselves, could not see any difference in the working alliance according to technological mode. This finding supports the idea that the emotional connection between client and therapist was not meaningfully impaired by technological intercession. Lombard and Ditton (1997) have provided theoretical support to the concept of *telepresence*, the ability to project and perceive social presence in technologically mediated communications.

Several therapists felt differently, however, no matter what outward appearances conveyed to raters.

- *Therapist:* All three modes could be useful for crisis management. When you are talking about deeper issues or are trying to work through stuff, the audio and the video had distance to them, and it's so hard to connect emotionally with the client. When you are face to face and having problems with someone, you lean forward or reach out and touch the person. When it's video, what can you do? When he's not looking at me in the TV, I can't move to show him that he's not looking at me.
- *Therapist:* With one client, she started crying and I just sat for a little bit. But the problem there is that I just felt so helpless like I wasn't there. I mean, I'm on a TV screen. There's no human contact or presence, and I think that's really important. I think that's one of the important pieces in the healing process and it wasn't there.
- *Therapist:* There's some sort of aspect that's kind of missing on the video . . . that wonderful, mythical presence.
- *Therapist:* It requires trust. That's a hard thing to develop if you haven't experienced it before. You have to have ego strength to be

able to withstand the kind of irony of it, you know, forming a relationship with someone who isn't really present, is there but is not there.

- *Therapist:* I had a client on video who was crying but I couldn't see it. When I finally realized that she was crying, I didn't know what to do. Usually if a client is crying in the session, I can sit there and wait for them to let it out or compose themselves, and I will usually hand them a box of tissues or something. But for me to speak over the video and say something felt intruding; I wanted her to feel my presence, but I didn't want to intrude.

Some therapists were surprised to find strong working alliances in spite of distance technology, and some thought the technology may even have enhanced the relationship:

- *Therapist:* The video, the only thing is that it's hard to tell sometimes if someone is tearing up or what the other nonverbals are. You can't see much beyond the face. So it's missing those sources of information, but I was really surprised how connected I felt with that client.
- *Therapist:* The client I had with the video was one of the strongest working alliances that I've ever developed with a client.
- *Therapist:* I got a sense that clients, once they got used to using the TV, that distance gave them a safeness. The clients compared to face-to-face didn't seem more rigid. They didn't sit up as straight, and they were more laid back, kind of like they were watching TV and doing this.
- *Therapist:* One client was real leery about being open about her issues, and so for her it was more comfortable being on video than being in the same room. She even said if she had been face-to-face she probably wouldn't have come or she would have dropped out. The flip side to the weakness of video, that distance I think, offers safety for some clients.

Theme 2: Working Blindfolded

The lack of visual evidence in the audio mode was a frequent theme in the interviews, requiring changes in therapists' habitual patterns of interacting and thinking:

- *Therapist:* The audio, the problem was having to always remember not to just nod your head, making everything verbal that I wanted to express. Empathy is hard to constantly express verbally. You feel awkward saying "uh-huh" all the time. But maybe as I got more practice it would be no big deal.
- *Therapist:* Whenever I was thinking about my clients, I would always forget that audio client because I didn't have a visual picture in my mind.
- *Therapist:* I like to read people's body language. And I didn't have that. And I'm just used to when people are experiencing strong emotion or dealing with something painful it's typical to sit in silence, just be with them. How do you do that on video or audio? If you are silent, they can misinterpret that in so many ways. In audio I found myself talking a lot more, filling the silence because I wanted them to know I was there. The only way I could express my presence was to speak.
- *Therapist:* With audio, I felt more self-conscious about how I spoke and what things I said because that's all she had, so I felt I qualified things more so that she wouldn't misunderstand me. I tried to use more humor in how I was saying things to make her feel more at ease because she couldn't see me smiling, and she couldn't see me using my hands or whatever, and a lot of times I would say, "I'm listening, but I'm writing something down," or when there were moments of silence I would fill up those moments of silence by saying what I was doing so that she didn't feel like I just dozed off or whatever.
- *Therapist:* This one guy was so uncomfortable with his emotions and so scared of them that having me in the room with him would have made it a safer place and maybe he would have felt better about experiencing his emotions and I could be a container for him in a way [making sure that he wouldn't fly out of control]. But as far as video and audio goes, I wasn't a container at all. There wasn't a safe place created to experience emotions in that way. Especially on audio only, I don't think I pushed clients to do that, because I didn't feel comfortable doing it, at all. Because there was no way I could tell how far they'd gone or how in control they felt.
- *Therapist:* I had a client who I thought had an eating disorder—I never saw him so I was never able to judge how thin he was or if

he was gaining weight or losing weight or did he look healthy? I didn't have that benefit of being able to see him.

Conversely, our clinicians often found unforeseen benefits in the distancing effect of audio-only treatment:

- *Therapist:* I like the audio, too; I think that was really freeing for the client. The ones who used the audio, I think that they were more open. I think the fact that they didn't have somebody looking at them—they were able to open up a lot more and to disclose some pretty serious stuff. For example an audio client disclosed his abusive side.
- *Therapist:* The guys in audio gave me more feedback [on the therapy process] than the guys that were face-to-face. You know, in the other modes god forbid they might say something that might hurt my feelings.
- *Therapist:* At least for two of my clients that I had on audio I believe that it wouldn't have worked as well in a face-to-face situation or even a video situation. The gentleman I just finished up with, I think that anonymity of working with me and me not knowing who he was helped him talk about himself.
- *Therapist:* What surprised me was that audio was, I felt, just as effective as video or face-to-face. In some senses I feel that audio is something that should be used as a teaching tool because as I used audio I found myself being able to pay more attention to clients, not only what they said but how they said it. The fluctuation in their voices. I paid more attention to the silences, to pauses. With face-to-face or video there are things to distract you from that, because you're watching the person. It got to the point that I looked forward to working with a client in the audio mode.

Several therapists noted that their preconceptions did not operate as automatically when they could not see their clients:

- *Therapist:* I didn't find myself making as quick of judgments about the person as I might have if they had come in with a certain appearance and a certain problem. Then I might have jumped to some conclusions that I wasn't able to jump to. I probably wasn't taking therapy off in certain directions right away based on the way they appeared or the way they acted.

- *Therapist:* When you see the client, all the other factors that play into what you read into a client, you know, like how they dress, you may read in they weigh too much, or that socioeconomics are part of the problem because of the way they look. I got a sense that a lot of people prejudge a lot on appearance. What the audio does is it teaches you to listen. You know, we always talk about listening to the client. Audio puts it in your face; that's all you got.

One clinician pointed out that the subjective perception of the audio experience may be distorted by the absence of visual activity:

- *Therapist:* With one audio client, it was interesting when my supervisor was watching the tape and I was listening to it again [therapists weren't allowed to view tapes of their audio sessions]. I had felt in session like there were these hour-long pauses between what we were saying. I felt as though I was taking too long to respond and that I had a little less room to maneuver. It seemed very slow and felt very awkward and that I wasn't able to respond well. When I listened to it later I realized that the pauses were only half a second or a second, so all this time I felt like I was fumbling around and thinking about how to come up with the right response really wasn't that long, but it felt a lot longer because there wasn't any of the usual stuff going on in between.

Theme 3: The Invisible Therapist

We did not expect therapists to emphasize the advantages of being unseen themselves, but several did:

- *Therapist:* The audio was not only freeing for the client but for me too. I know if you see my videos in audio mode, I'm like totally relaxed. I had my feet up, so that was a nice mode for me too. I don't do that with face-to-face clients.
- *Therapist:* The most comfortable was probably audio, to a certain extent, because I didn't have eyes on me. I could just sit there and do my thing.
- *Therapist:* I learned that these restricting clothes [worn in face-to-face and video therapy] are not me. I do better work if I'm not

confined. I learned not to wear binding and constricting things. I'll be a California kind of therapist.

- *Therapist:* I was most comfortable in audio. Because I was more relaxed. When you're doing face-to-face I think you have got to have a certain posture. I think that most of the clients I had that way were more relaxed. They seemed like they liked the anonymity too.
- *Therapist:* In the audio I could be completely relaxed and focus only on what they were saying, and in some ways that helped them to be more honest because it wasn't face-to-face. So I didn't feel as embarrassed. I think they were more open about what they said and a little more free about the way they expressed themselves. I think audio was easier for me because I'm someone who enjoys talking on the phone. I tend to be more verbally expressive. So that was fine for me.
- *Therapist:* The audio was good because race never played into it, or me being in a wheelchair didn't play into it. It was just two people working without all those other areas popping up about if I was Black or if I was disabled. My face-to-face and video clients would eventually say, "You have it much more difficult than I do." They try to compare the situation they think I am in. In audio that never became an issue.

One of our therapists, however, found a communication problem due to being unseen:

- *Therapist:* When I'm in situations where I'm not especially comfortable or when I get nervous, I lose confidence in my English-speaking abilities since it is my second language. Usually I feel like I can kind of compensate for any misunderstandings in the way I speak by my body language and my demeanor. With audio, I felt that if I said something that didn't make sense, which I often do, I couldn't see the client give me that confused look.

Theme 4: Approaches to Psychotherapy

In our clinic, we encouraged clinicians to follow a five-session cognitive-behavioral model. However, for reasons of ecological validity, we allowed them to vary from this model according to their own judgment, just as a real-world therapist would. Most of the

therapists had ideas about which orientations to treatment could work over which modes of delivery:

- *Therapist:* A psychodynamic therapist would do really well with the audio, especially psychoanalytic, because you don't look at your client anyway. But I'm more humanistic and interpersonal, like I use the relationship more and look at how it was similar to other relationships. You can do this in all the modes, which I did.
- *Therapist:* If you had your clients journaling or role-playing, things that are more interactive, that would be difficult. If it was video or audio, we had to make sure you had stuff xeroxed, and if you didn't, figure out how to deal with it. [At our clinic, before each session the site manager made copies of homework for the therapist in audio or video modes.] I thought in one situation about using the two-chair technique . . . I don't know how that would work in the audio because the movement is such a big part of it. In audio maybe the person would feel silly moving back and forth.
- *Therapist:* With the audio client, her therapy was exposure therapy to her fear of heights, and so normally under those circumstances I would have gone with her to experience some of the things that she was afraid of as part of the exposure therapy. We would have gone to the University Inn, right across the street, all the way to the top. I made up for the limitations by really concentrating on the homework and trying to play the homework out as much as possible during the session. A lot of imaginal in-session exposure. I can imagine that, for example, if a compulsive washer had to be exposed to dirt and all that stuff, that her doing it on her own would've been incredibly difficult, at least based on my experience with those problems.
- *Therapist:* In exposure therapy, just your physical presence and reassurance is important in doing certain tasks with them. If I had a client with a driving phobia I couldn't—well, I suppose we could talk on the phone while they are driving, but probably not such a good idea. Or I could talk to a friend of theirs or a spouse or someone and sort of get a support person who could then go and do these sorts of tasks with them.

Theme 5: Client Differences

Therapists had strong opinions about the types of problems that were suitable and unsuitable for the distance modes of treatment. (However, two therapists who treated eating disordered clients over audio had differing points of view on the effect of the mode, although both thought it increased client comfort.) Looking at all three types of treatment delivery, the idea of matching problem and delivery mode came up in almost every interview:

- *Therapist:* I had a client who was audio only who wanted to quit smoking. That was easily done, but we didn't deal with emotions. We didn't deal with other things in his life, just quitting smoking. But then I had another client who was eating disordered and was audio only, and I don't think it worked. For her, body image was a big issue and I never saw her. In some ways it may have made her feel more comfortable, but maybe she needed to be a little more uncomfortable. Then the video only played into another client whose issue was paranoia. He wanted to know if I really cared about him or if he was just being taped so others could watch him. He was paranoid that I was just a computer not a person, and the TV constantly reminded him that he was being taped. We just couldn't get past this because every time he looked at me he was reminded that I really wasn't there.
- *Therapist:* I would be real wary of seeing people who are severely depressed and suicidal and offering them video only. And someone who's schizophrenic working on video, that might be one of their main hallucinations, "People are talking to me on the TV set."
- *Therapist:* The woman I had in audio had issues about self-esteem and appearance, and since I couldn't see her I think that made a little bit of difference in how the therapy developed. The therapy went well with that client.
- *Therapist:* I had one client in video who had some issues with trying new things. She wanted to go out and do new things. I think that helped because she was doing something new in doing video therapy. She felt uncomfortable about it but when she decided *this* wasn't really a big deal. . . .
- *Therapist:* I had a client with OCD [obsessive compulsive disorder] that was audio, but I guess he was doing some ritual stuff,

but I could not see. So that might have been additional information that would have been helpful.

Besides matching for the type of problem, all the therapists also brought up matching other client characteristics with treatment mode. Background and personality, they felt, ideally would be taken into account when assigning clients to distance therapy:

- *Therapist:* One client had a very extensive background in counseling. Actually the audio was better for that client because it wasn't the same old thing. It changed it. She had to go by what I said and I had to go by what she said. With a sense of anonymity, she could be more emotional because she didn't feel as vulnerable as in typical counseling. I also had a man who had been a counselor for people who are drug abusers. He didn't really like being on the other side of the chair. This was video, so it gave him some distance, some space in the sense that it wasn't what he did. I mean it wasn't the same way he did it. I think in those two cases it helped a lot, the clients having to adjust to the situation and not be in the same old routine.
- *Therapist:* The limitations depend on the client. Like how comfortable do they feel? Are they the kind of person that has problems talking about how they feel? How do they express emotions? Are they very verbal? Do they make a lot of eye contact? Do they fidget a lot? So if the client doesn't make eye contact, has trouble talking, I would feel uncomfortable putting them in anything besides face-to-face. Because there is more of a demand on the client to talk more on audio. I still think you're losing information over the technical media. You may have to do a cost-benefit analysis.
- *Therapist:* There might be clients for whom audio is better, clients who wouldn't otherwise come to therapy. Clients who'd be concerned about being in the same room as the therapist. If it makes them more comfortable to be in their own space, if that will open it up to a lot more people, that would be great. And I don't think you can't do it. This has taught me that you can do it, that you can still do a good job of therapy over a different medium.
- *Therapist:* It seems like people who were more secure in themselves or more confident tended to do better in the audio and the

video. In clients who didn't have a lot of coping mechanisms, I had to do a lot more work in therapy, and it was harder to do that with video and audio.

- *Therapist:* I would screen ambivalent people into more face-to-face.
- *Therapist:* That audio client was an easy one. She had a very specific problem, and I felt like it was a good therapeutic relationship; but had it been a difficult client, I'm not sure what I would have done.
- *Therapist:* My video client was very amusing and very expressive, and she used her hands a lot, and her tone of voice was very marked, her intonations, and she was just very personable as a client. The other client that was through video was much more reserved and much more just quiet and not as open, and it took a long time for us to establish a rapport.
- *Therapist:* I think that a client that will benefit in audio has to be one of those learners who is relatively quick and can process a lot of verbal information and doesn't need those visual cues so much. But there aren't a lot of clients like that.
- *Therapist:* At first with this video thing, my client was like, "I don't like this. I don't like this. I don't feel I can feel close to my therapist," but then she really liked it. Then she loved it. I mean, those last two sessions she's like, "I think that this has been a wonderful experience because I felt that with the video I had more privacy and more personal space, that I didn't have somebody in my presence sharing with this, and it made me take responsibility for my emotions more." It was therapeutic for her because she felt like, well, one of her problems was she's just not taking enough responsibility for her life and her emotions, and this way it didn't allow for anybody to comfort her in a physical, like, in a presence way. Usually she would've become much more needy in a therapeutic relationship.
- *Therapist:* I think anything where there is going to be a lot of personal disclosure it is easier for the client to open up earlier [on audio]. Because they are more anonymous and I didn't know who they were.
- *Therapist:* One client, she's glad she doesn't have to be face-to-face. Because she likes to keep her distance from people, I think initially it made therapy easier for her.

- *Therapist:* If my client were in an audio mode, she would feel like she was revealing herself and not really know what's on the other side in some way. She might feel more exposed.

Theme 6: Natural Adaptations

When plainly asked their preferences, most therapists chose face-to-face (7 out of 10). Two therapists liked audio best, and one liked all modes equally. Interestingly, the three therapists *not* choosing face-to-face were also the three who did the most work in audio. This suggests that familiarity with the mode interacts with preference, and indeed many of the therapists choosing face-to-face said that their choice had mostly to do with familiarity.

Clients were given satisfaction rating sheets at the close of treatment. An analysis of variance showed that clients were very satisfied (an average rating of 5.97 on a 7-point scale) with their treatments, and there were no significant differences in satisfaction among the conditions. This is a provocative finding, in that clients in audio and video modes experienced the supposed disadvantages of distance treatment without the obvious advantages—that is, not having to travel far or being able to receive treatment at home. The fact that clients who finished treatment in the distance modes were just as satisfied as those in the traditional mode lends hope for the future of therapy over a distance. However, we must note that the highest dropout rate was among clients in the distance modes (though our dropout rate in general was very low, less than 14%: five clients in audio, four in video, and two in face-to-face). Therapists' satisfaction ratings averaged 5.67 on a scale of 1 to 7, with no significant differences among modes of delivery.

A major theme in all of the interviews was the ability of both therapists and clients to adjust to whatever situation they encountered:

- *Therapist:* I was expecting the audio to be the hardest because, as I said, I am such a visual person. That wasn't what happened.
- *Therapist:* I was mildly surprised about how well people responded to it, and some people actually made comments like, "You know, it's kind of cool to be on this video thing," and I didn't think it was going to work as well as it did.
- *Therapist:* I've learned that people are pretty adaptable and that when there's a need to learn to make allowances, they can do the

audio, they can do the video. I think I was more skeptical going into it. I thought they would be very resistant, and they weren't at all.

- *Therapist:* I think the client actually just adapts to the mode they're in, and so they might say to themselves, "Wow, you know, this video thing is good; if I were face-to-face this would be more uncomfortable," without really having any idea how face-to-face would have been. They just adapt.
- *Therapist:* You make adjustments: it's just like from client to client, from mode to mode you make the adjustments.

IMPLICATIONS FOR CLINICAL TRAINING AND PRACTICE

The thoughts and feelings of the clinicians in this research project may be taken to heart by pioneers in all kinds of distance therapy. A notable finding was that most of the nonconventional features of technologically mediated counseling entailed both the expected disadvantages and some surprising advantages. For example, although the lack of visual evidence in the audio mode frustrated therapists, some also found that it kept them from making judgments based on appearance and that it refined their listening skills. Both of these advantages reflect sound traditional practices, and the use of audio counseling in training programs is suggested. Our study highlights many areas where training for futuristic modes of delivery should focus: the matching of problem types and clients to delivery systems, the choice of treatment approaches considering media limitations, and making full use of the adaptability of each client and therapist pair, to name a few.

Another intriguing theme is the freeing nature of the physical separation in video and audio treatment, mentioned by many of the therapists. It seems to relate to an oft-heard claim that some people are more expressive and truthful in letters, over e-mail, or on the telephone than they are in person. In fact, one study found that people were more likely to admit alcohol abuse over the telephone than in a face-to-face interview (Kobak et al.,1997). If distance engenders honesty and feelings of safety, the new technologies may serve some groups better than face-to-face ever did. Social phobics, schizophrenics, agoraphobics, and the personality disordered are

populations for whom subjectively "safe" treatment deliveries could be godsends. Distance modes could be used to ease such clients into treatment, followed by face-to-face contact, or could be used intermittently to maintain the therapeutic relationship through rough periods when otherwise these clients tend to drop out. Such possibilities should inspire further research.

CONCLUSION

Our research strongly suggests that technologically mediated treatment may be a substitute for, and in some cases an improvement upon, traditional face-to-face therapy. We found no barriers that were insurmountable, and we were impressed by the adaptability of both clients and therapists. Further research is needed on the best ways to train clinicians and work around the problems distance therapy presents. With the proper support and consultation as they make the transition, we believe that well-trained practitioners already hold the tools they need to send their touch through cyberspace.

REFERENCES

Day, S. X. (1999). *Psychotherapy using distance technology: A comparison of process in face-to-face, video, and audio treatments*. Unpublished doctoral dissertation, University of Illinois at Urbana-Champaign.

DeRubeis, R. J., & Crits-Christoph, P. (1998). Empirically supported individual and group psychological treatments for adult mental disorders. *Journal of Consulting and Clinical Psychology, 66*, 37–52.

Kobak, K. A., Taylor, L. vH., Dottl, S. L., Greist, J. H., Jefferson, J. W., Burroughs, D., Mantle, J. M., Katzelnick, D. J., Norton, R., Henk, H. J., & Serline, R. C. (1997). A computer-administered telephone interview to identify mental disorders. *Journal of the American Medical Association, 278*, 905–910.

Kraut, R., Patterson, M., Lundmark, V., Kiesler, S., Mudopadhyay, T., & Scherlis, W. (1998). Internet paradox: A social technology that reduces social involvement and psychological well-being? *American Psychologist, 53*, 1017–1031.

Lombard, M., & Ditton, T. (1997). *At the heart of it all: The concept of telepresence* [On-line]. Available: http://www.ascusc.org/jcmc/vol3/issue2/lombard.html.

Schneider, P. L. (1999). *A comparison of outcome variables in psychotherapy: Distance technology versus face-to-face*. Unpublished doctoral dissertation, University of Illinois at Urbana-Champaign.